		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011643

Facility Name: SUNSET HOME

Address: 418 WASHINGTON (Number) QUINCY (City) 62301 (Zip Code)

County: ADAMS

Telephone Number: 217-223-2636 **Fax #** 217-223-9867

IDPA ID Number: 370661224-001

Date of Initial License for Current Owners: NOT AVAILABLE

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RUTH STOWE **Telephone Number:** 217-223-2636 EXT 311

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/00 to 9/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 12/27/01 (Date)
(Type or Print Name) JUDY KIRLIN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) 12/24/01 (Date)
(Print Name and Title) TIMOTHY WIEWEL, PROPRIETOR
(Firm Name & Address) TIMOTHY J WIEWEL CPA, PO BOX 1028 QUINCY IL 62306
(Telephone) 217-223-2245 Fax # 217-223-7580

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 01/29/2001

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	138	Intermediate (ICF)	148	52,820	3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	81	31,635	5
6		ICF/DD 16 or Less			6
7	253	TOTALS	248	91,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	489	154	1,668	2,311	8
9	SNF/PED					9
10	ICF	22,489	28,523		51,012	10
11	ICF/DD					11
12	SC	3,632	14,113		17,745	12
13	DD 16 OR LESS					13
14	TOTALS	26,610	42,790	1,668	71,068	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.76%

D. How many bed-hold days during this year were paid by Public Aid? 30 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
INDEPENDENT LIVING UNITS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 7 and days of care provided 1,428

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	465,946	30,946	17,250	514,142		514,142		514,142			1
2	Food Purchase		248,725		248,725		248,725		248,725			2
3	Housekeeping	210,772	42,026	2,283	255,081		255,081		255,081			3
4	Laundry	88,495	24,663	3,212	116,370		116,370		116,370			4
5	Heat and Other Utilities			359,502	359,502		359,502		359,502			5
6	Maintenance	153,099	36,397	71,190	260,686		260,686		260,686			6
7	Other (specify):*											7
8	**TOTAL General Services**	918,312	382,757	453,437	1,754,506		1,754,506		1,754,506			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,796,385	116,057	93,723	3,006,165		3,006,165		3,006,165			10
10a	Therapy	118,349	457	34,461	153,267		153,267		153,267			10a
11	Activities	124,585	9,691	4,794	139,070		139,070		139,070			11
12	Social Services	60,686	36	5,164	65,886		65,886		65,886			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,100,005	126,241	138,142	3,364,388		3,364,388		3,364,388			16
	C. General Administration											
17	Administrative	74,495			74,495		74,495		74,495			17
18	Directors Fees											18
19	Professional Services			30,515	30,515		30,515	(593)	29,922			19
20	Dues, Fees, Subscriptions & Promotions			42,549	42,549		42,549		42,549			20
21	Clerical & General Office Expenses	256,475	15,512	102,771	374,758		374,758		374,758			21
22	Employee Benefits & Payroll Taxes			854,060	854,060	(18,900)	835,160		835,160			22
23	Inservice Training & Education			1,677	1,677		1,677		1,677			23
24	Travel and Seminar			12,834	12,834		12,834	(540)	12,294			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,776	70,776		70,776		70,776			26
27	Other (specify):* BAD DEBT			4,977	4,977		4,977	(4,977)				27
28	**TOTAL General Administration**	330,970	15,512	1,120,159	1,466,641	(18,900)	1,447,741	(6,110)	1,441,631			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,349,287	524,510	1,711,738	6,585,535	(18,900)	6,566,635	(6,110)	6,560,525			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SUNSET HOME #0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			335,673	335,673	(42,157)	293,516		293,516			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,095	10,095		10,095	(764)	9,331			32
33	Real Estate Taxes			254	254		254		254			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			346,022	346,022	(42,157)	303,865	(764)	303,101			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,433		21,433		21,433		21,433			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,023	90,023		90,023		90,023			42
43	Other (specify):* SEE ATTACHED			162,506	162,506	61,057	223,563	(223,563)				43
44	**TOTAL Special Cost Centers**		21,433	252,529	273,962	61,057	335,019	(223,563)	111,456			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,349,287	545,943	2,310,289	7,205,519		7,205,519	(230,437)	6,975,082			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(764)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(593)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,977)	27		24
25	Fund Raising, Advertising and Promotional	(133,164)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(90,939)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (230,437)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (230,437)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SUNSET HOME

ID# 0011643

Report Period Beginning: 10/1/00

Ending: 9/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VILLA INDEP LIVING UNIT	$ (90,399)	43	1
2	OUT OF STATE TRVEL	(842)	24	2
3	2001 TRAVEL & SEMINAR PAID 2000	302	24	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(90,939)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses / A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(593)	0	0	0	0	0	0	0	0	0	0	(593)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(540)	0	0	0	0	0	0	0	0	0	0	(540)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,977)	0	0	0	0	0	0	0	0	0	0	(4,977)	27
28	**TOTAL General Administration**	(6,110)	0	0	0	0	0	0	0	0	0	0	(6,110)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,110)	0	0	0	0	0	0	0	0	0	0	(6,110)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **SUNSET HOME** **# 0011643** **Report Period Beginning:** **10/1/00** **Ending:** **9/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(764)	0	0	0	0	0	0	0	0	0	0	(764)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(764)	0	0	0	0	0	0	0	0	0	0	(764)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(223,563)	0	0	0	0	0	0	0	0	0	0	(223,563)	43
44	**TOTAL Special Cost Centers**	(223,563)	0	0	0	0	0	0	0	0	0	0	(223,563)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(230,437)	0	0	0	0	0	0	0	0	0	0	(230,437)	45

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MERCANTILE		X	OPERATIONS LINE OF CREDIT		8/3/00	$ 150,000	$ 95,266	12/21/2007	0.0950	$ 9,331	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 150,000	$ 95,266			$ 9,331	9
	B. Non-Facility Related*											
10	GIFT ANNUITIES		X	NONE							764	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 764	14
15	TOTALS (line 9+line14)						$ 150,000	$ 95,266			$ 10,095	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 254	2
3. Under or (over) accrual (line 2 minus line 1).	$ 254	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SUNSET HOME COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0011643

CONTACT PERSON REGARDING THIS REPORT RUTH STOWE

TELEPHONE 217-223-2636 EXT 311 FAX #: 217-223-9867

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-2-0973-000-00	810 s 4th	$ 52.00	$ 52.00
2.	23-2-0926-000-0	701 s 4th	$ 149.00	$ 149.00
3.	23-2-0917-000-00	700 s 5th	$ 76.00	$ 76.00
4.	23-2-0972-000-00	812 s 4th	$ (23.00)	$ (23.00)
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 254.00	$ 254.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 144,818 B. General Construction Type: Exterior BRICK Frame STEEL-FIREPROOF Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

VILLA APARTMENTS 16-2BEDROOM UNITS 16,000 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	199,487		$ 102,419	1
2	PARKING LOT ADDITIONAL	15,000	1996-1997	86,288	2
3	TOTALS	214,487		$ 188,707	3

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1958	1958	$ 354,000	$ 7,080	50	$ 7,080	$	$ 307,980	4
5	138		1971	1971	1,218,562	24,371	50	24,371		731,110	5
6	49		1972	1972	472,577	9,452	50	9,452		281,189	6
7	5		1987	1987	68,497	3,425	20	3,425		48,235	7
8											8
	Improvement Type**										
9	FIXED EQUIPMENT			1971	814,827					814,827	9
10	FIXED EQUIPMENT			1972	253,064					253,063	10
11	FIXED EQUIPMENT			1978	280,726	11,229	25	11,229		264,124	11
12	FIXED EQUIPMENT			1979	13,938					13,938	12
13	FIXED EQUIPMENT			1980	3,693	148	25	148		3,190	13
14	FIXED EQUIPMENT			1984	23,531					23,531	14
15	FIXED EQUIPMENT			1985	117,689	5,615	5,10,15,20	5,615		97,331	15
16	FIXED EQUIPMENT			1986	15,992	290	10,15	290		15,983	16
17	FIXED EQUIPMENT			1987	12,320	564	10,15,20	564		10,325	17
18	FIXED EQUIPMENT			1988	8,162	241	10,20	241		6,640	18
19	FIXED EQUIPMENT			1989	4,670	311	15	311		3,890	19
20											20
21	FIXED EQUIPMENT			1993	259,307	14,040	10,20	14,040		115,925	21
22	FIXED EQUIPMENT			1995	188,017	9,657	10,15,20	9,657		59,945	22
23	FIXED EQUIPMENT			1996	10,809	1,037	10,15	1,037		5,050	23
24	2 AO SMITH GAS BOILERS			1997	30,000	1,500	20	1,500		6,750	24
25	9 KEYPADS WITH ZONE CARDS(DOORS)			1997	2,343	156	15	156		547	25
26	CALL LIGHT SYSTEM 2 WEST			1999	5,340	356	15	356		534	26
27	SMOKE DETECTORS DINING ROOM 2,3,4			2000	2,524	168	15	168		252	27
28	POWER WIRING UPGRADE EMERGENCY GENERATOR			2000	10,100	505	20	505		758	28
29	REPLACE SEPARATOR KITCHEN CHILLER			2000	2,720	136	20	136		204	29
30	NEW CHILLER REPLACEMENT			2000	208,923	10,446	20	10,446		15,669	30
31	KEY LOCKS AND WINDOW PULLS			2000	2,160	144	15	144		216	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	6 DUCT DETECTORS	1997	$ 3,118	$ 156	20	$ 156	$	$ 546	37
38	4 JANITOR CLOSET DOORS	1998	2,605	130	20	130		456	38
39	FIRE ALARM LADDER	1998	12,884	859	15	859		3,006	39
40	WEST ELEVATOR RENOVATION	1998	4,500	225	20	225		788	40
41	GENERATOR LOAD BANK	1998	24,518	1,226	20	1,226		4,291	41
42	35,98 TON AIR COOLED CHILLERS SO BLDG	1998	25,357	1,690	15	1,690		5,815	42
43	NORTH ELEVATOR RENOVATION	1998	63,500	3,175	20	3,175		11,113	43
44	FIRE ALARM CONTROL PANEL	1998	7,142	357	20	357		1,250	44
45	2 HOUR FIRE WALL IN VERTICAL SHAFTS	1998	64,994	3,250	20	3,250		11,295	45
46	CHILLER 35.8 TON MODIFICATION	1999	10,257	684	15	684		1,710	46
47	UPGRADE 4 S&N FIRE ALARM MODULES	1999	3,404	170	20	170		426	47
48	BUILDINGS & IMPROVEMENTS	1958	12,000					12,000	48
49	BUILDINGS & IMPROVEMENTS	1972	51,124	1,023	50	1,023		29,669	49
50	BUILDINGS & IMPROVEMENTS	1979	13,639	273	50	273		6,140	50
51	BUILDINGS & IMPROVEMENTS	1977	14,179					14,179	51
52	BUILDINGS & IMPROVEMENTS	1978	442,103	8,842	50	8,842		207,902	52
53	BUILDINGS & IMPROVEMENTS	1980	1,185					1,185	53
54	BUILDINGS & IMPROVEMENTS	1981	7,902					7,902	54
55	BUILDINGS & IMPROVEMENTS	1982	14,161					14,161	55
56	BUILDINGS & IMPROVEMENTS	1983	17,260	863	20	863		15,809	56
57									57
58	BUILDINGS & IMPROVEMENTS	1985	272,013	6,800	40	6,800		110,949	58
59									59
60	BUILDINGS & IMPROVEMENTS	1987	321,886	14,347	10,20	14,347		244,144	60
61	BUILDINGS & IMPROVEMENTS	1988	36,315	239	10,20	239		34,785	61
62	BUILDINGS & IMPROVEMENTS	1989	164,241	7,313	10,20	7,313		110,758	62
63	BUILDINGS & IMPROVEMENTS	1990	64,734	3,237	20	3,237		36,641	63
64	BUILDINGS & IMPROVEMENTS	1992	11,222	967	10,20	967		8,676	64
65	BUILDINGS & IMPROVEMENTS	1993	37,801	2,214	5,10,20	2,214		21,355	65
66	BUILDINGS & IMPROVEMENTS	1994	9,466	382	5,20	382		4,692	66
67	BUILDINGS & IMPROVEMENTS	1995	99,649	6,990	5,10,15	6,990		48,939	67
68	BUILDINGS & IMPROVEMENTS	1996	33,788	2,124	5,20	2,124		15,139	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,231,438	$ 168,407		$ 168,407	$	$ 4,066,927	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,231,438	$ 168,407		$ 168,407	$	$ 4,066,927	1
2	BLINDS GARDEN ROOM	1997	935	94	10	94		421	2
3	CARPET GARDEN ROOM	1997	1,154	231	5	231		1,038	3
4	REMODEL GARDEN ROOM	1997	44,549	2,227	20	2,227		10,116	4
5	CERAMIC FLOOR EMPLOYEE DINING ROOM	1997	1,907	95	20	95		429	5
6	CARPET MAIN DINING ROOM	1997	8,323	1,665	5	1,665		7,491	6
7	BLINDS DECK/LOUNGE	1997	2,490	249	10	249		1,121	7
8	CARPET DECK/LOUNGE	1997	8,485	1,697	5	1,697		7,637	8
9	REMODEL DECK/LOUNGE	1997	332,574	16,629	20	16,629		74,829	9
10	2 DRAPES DINING ROOM	1997	1,056	106	10	106		370	10
11	6 HUNTER BLINDS DINING ROOM	1997	638	64	10	64		223	11
12									12
13	BLINDS MEDICAL RECORDS ROOM	1997	978	98	10	98		342	13
14	REMODEL FIRST FLOOR LOBBY	1998	99,145	4,957	20	4,957		17,350	14
15	CARPET FIRST FLOOR LOBBY	1998	3,163	633	5	633		2,214	15
16	DRAPES FIRST FLOOR LOBBY	1998	1,449	145	10	145		507	16
17	BLINDS FIRST FLOOR LOBBY	1998	662	66	10	66		232	17
18	REMODEL 257+259 PAINT & CARPET	1998	2,585	129	20	129		452	18
19	DRAPES 457+271 WEST	1999	986	99	10	99		247	19
20	BLINDS ROOM 157 & MINIS ICE CREAM SHOP	1999	710	71	10	71		178	20
21	VERTICAL BLINDS OFFICE 1 WEST	1999	1,988	199	10	199		497	21
22	FIRE PROTECTION BOXES ON LIGHTS	2000	23,606	1,180	20	1,180		1,180	22
23	TILE 1ST WEST & SOWEST HALLS	2000	4,633	232	20	232		232	23
24	DRYWALL SUNSET HALL	2000	4,600		20				24
25	TILE SUNSET HALL	2000	2,605		20				25
26	ALZHEIMER BUILDING	2001	2,500,281		30				26
27	WINDOW BLINDS VALANCES 2 NORTH	2001	4,445	222	10	222		222	27
28	SHADES FOR SCU CORNER WINDOW	2001	1,282	64	10	64		64	28
29	GATES SCU	2001	1,685	56	15	56		56	29
30	NURSES STATION 2NORTH	2001	1,550	39	20	39		39	30
31	AUTO DOOR SMOKE ROOM 1SW	2001	2,596	130	10	130		130	31
32	DEPRECIATION ON BLDG & IMPROV DISPOSED 2001			3,738		3,738			32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,292,498	$ 203,522		$ 203,522	$	$ 4,194,544	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,292,498	$ 203,522		$ 203,522	$	$ 4,194,544	1
2	LAND IMPROVEMENTS								2
3	FOUNTAIN	1975	2,807					2,807	3
4	FLAG POLE	1978	495					495	4
5	PARKING LOT & CURB	1979	6,425					6,425	5
6	1992 IMPROVEMENTS	1992	56,865	5,687	10	5,687		54,990	6
7	1995 IMPROVEMENTS	1995	18,601	1,550	12	1,550		9,946	7
8									8
9									9
10	BRICK WALL 5TH WASHINGTON	1997	4,800	192	25	192		864	10
11	PARKING LOT A & B 500, 5001, 5003 WASHINGTON	1999	44,219	3,685	12	3,685		9,213	11
12	FIRE HYDRANT	2000	5,383	359	15	359		2,153	12
13	LANDSCAPE WHITE ROCK 4TH ST.	2000	3,784	378	10	378		2,270	13
14	LANDSCAPE YARD	2000	1,700	170	10	170		1,020	14
15	IRIGATION SYSTEM	2000	3,692	74	25	74		74	15
16	REPLACE CONCRETE	2000	3,000	100	15	100		100	16
17	SHRUBS LANDSCAPING	2001	1,952	98		98		98	17
18	DEPRECIATION ON LAND IMPROV DISPOSED			989		989			18
19									19
20	FIXED EQUIPMENT CONTINUED								20
21	SPEAKERS/AMP SCU	2000	2,546		15				21
22	TELEPHONE SYSTEM SCU	2000	2,695		10				22
23	BOILER END CENTER SECTION	2000	11,787		15				23
24	UPGRADE SPRINKLER PIPING	2000	10,825		25				24
25	NURSE CALL SYSTEM 2NORTH	2000	5,267		20				25
26	2 15HP CIRCULATION PUMPS	2000	11,288		15				26
27	GENERATOR UPGRADE	2000	1,626		20				27
28	EXPANSION TANK FOR BOILER	2001	2,780	93	15	93		93	28
29	FIRE ALARM NETWORKING	2001	2,041	51	20	51		51	29
30	CABLE/WIRE 2SOUTH COMPUTERS	2001	2,801	70	20	70		70	30
31	TOSHIBA VOICEMAIL SYSTEM	2001	5,156	258	10	258		258	31
32	DEPRECIATION ON FIXED EQUIP DISPOSED			151		151			32
33	ROUNDING		(6)	(4)		(4)		(17)	33
34	TOTAL (lines 1 thru 33)		$ 9,505,027	$ 217,423		$ 217,423	$	$ 4,285,454	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 600,885	$ 64,317	$ 64,317	$	5 TO 25	$ 351,214	71
72	Current Year Purchases	95,348	4,733	4,733		5,10,15	4,733	72
73	Fully Depreciated Assets	138,404					138,404	73
74	DEPR ASSETS DISPOSED		1,262	1,262				74
75	TOTALS	$ 834,637	$ 70,312	$ 70,312	$		$ 494,351	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINTENANCE	97 3/4 TON GMC & PLOW	1997	$ 23,521	$ 5,781	$ 5,781	$	4,5	$ 20,234	76
77	RESIDENT TRANSPORT	FORD BUS	1990	34,485					34,485	77
78	RESIDENT TRANSPORT	1994 FORD VAN	1995	36,216					36,216	78
79										79
80	TOTALS			$ 94,222	$ 5,781	$ 5,781	$		$ 90,935	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,622,593	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 293,516	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 293,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,870,740	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	VILLA INDEP LIVING UNITS	$ 1,677,631	$ 42,157	$ 541,099	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 1,677,631	$ 42,157	$ 541,099	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

COMMUNITY COLLEGE TRAINS AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 26,124	$		$ 26,124	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			1,800			1,800	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			7,838			7,838	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				21,433		21,433	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 35,762	$ 21,433		$ 57,195	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 16,736	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	629,363		3
4	Supply Inventory (priced at COST)	56,357		4
5	Short-Term Investments	367,940		5
6	Prepaid Insurance	39,487		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,109,883	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	285,327		12
13	Land	188,707		13
14	Buildings, at Historical Cost	9,505,026		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	928,859		16
17	Accumulated Depreciation (book methods)	(4,870,740)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,148,498		21
22	Other Long-Term Assets (spe SEE ATTACHED	2,501,022		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,686,699	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,796,582	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 94,423	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	402,909		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,191		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	EST HEALTH CLAIMS INCURRED	20,936		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 525,459	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	95,266		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	REFUNDABLE FEES	145,350		43
44	DEFERRED REVENUE	52,773		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 293,389	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 818,848	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,977,734	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,796,582	$	48

***(See instructions.)**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,219,109	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,219,109	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(241,375)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (241,375)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,977,734	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,795,622	1
2	Discounts and Allowances for all Levels	(584,924)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,210,698	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,261	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,155	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,416	23
	D. Non-Operating Revenue		
24	Contributions	482,581	24
25	Interest and Other Investment Income***	107,530	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 590,111	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE LIST ATTACHED	155,919	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 155,919	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,964,144	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,754,506	31
32	Health Care	3,364,388	32
33	General Administration	1,466,641	33
	B. Capital Expense		
34	Ownership	346,022	34
	C. Ancillary Expense		
35	Special Cost Centers	183,939	35
36	Provider Participation Fee	90,023	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,205,519	40
41	**Income before Income Taxes (line 30 minus line 40)****	(241,375)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (241,375)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,918	2,086	$ 50,767	$ 24.34	1
2	Assistant Director of Nursing	1,898	1,966	40,173	20.43	2
3	Registered Nurses	15,541	16,615	286,372	17.24	3
4	Licensed Practical Nurses	70,438	77,649	979,358	12.61	4
5	Nurse Aides & Orderlies	141,433	153,625	1,362,830	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,455	8,528	101,123	11.86	8
9	Activity Director	1,842	2,086	26,397	12.65	9
10	Activity Assistants	9,880	11,249	79,381	7.06	10
11	Social Service Workers	3,854	4,207	39,732	9.44	11
12	Dietician					12
13	Food Service Supervisor	1,902	2,086	32,220	15.45	13
14	Head Cook	1,860	2,086	26,416	12.66	14
15	Cook Helpers/Assistants	42,469	46,176	340,162	7.37	15
16	Dishwashers	7,573	8,265	67,148	8.12	16
17	Maintenance Workers	10,631	11,359	114,896	10.11	17
18	Housekeepers	26,053	28,258	200,011	7.08	18
19	Laundry	8,969	9,965	77,733	7.80	19
20	Administrator	2,006	2,246	74,495	33.17	20
21	Assistant Administrator					21
22	Other Administrative	5,687	6,258	93,267	14.90	22
23	Office Manager					23
24	Clerical	14,150	15,776	163,208	10.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,782	2,997	25,793	8.61	31
32	Other Health C: SEE ATTACHED	8,777	9,342	89,271	9.56	32
33	Other(specify) SEE ATTACHED	4,873	5,287	78,534	14.85	33
34	TOTAL (lines 1 - 33)	391,991	428,112	$ 4,349,287 *	$ 10.16	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 8,105	1-3	35
36	Medical Director		3,600	10-3	36
37	Medical Records Consultant		1,890	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,720	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,894	11-3	44
45	Social Service Consultant		1,894	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,103		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY KIRLIN	ADMINISTRATOR	0	$ 74,495
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,495

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
TIMOTHY J WIEWEL CPA	AUDITING/ACCTG	$ 12,501
SCHOLZ LOOS PALMER SIEBER	LEGAL	9,662
SCHOLZ LOOS PALMER SIEBER	LEGAL	593
FR&R HEALTHCARE	MEDICARE ACCTG	7,759
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,666
Unemployment Compensation Insurance	19,225
FICA Taxes	327,297
Employee Health Insurance	242,823
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION	104,190
DISABILITY INSURANCE	5,477
PHYSICALS	6,912
EMPLOYEE AWARDS	19,470
ADJUST FUND RAISING COSTS	(18,900)
TOTAL (agree to Schedule V, line 22, col.8)	$ 835,160

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,554
Health Care Worker Background Check	
(Indicate # of checks performed 96)	1,152
HEALTH CARE FINANCING ADM	6,240
LIFE SERVICES NETWORK DUES	8,556
TRI STATE HEALTH CARE COALITION	3,746
OTHER VARIOUS DUES	7,301
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,549

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,690
2001 EXPENSES PAID 2000	302
2002 EXPENSES PAID 2001	0
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,992

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SUNSET HOME # 0011643 Report Period Beginning: 10/1/00 Ending: 9/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LIFE SERVICES NETWORK $8,556

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 70,288 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 90,023
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: TIMOTHY J WIEWEL CPA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.